

# The Legislature of the State of New Mexico

50th Legislature, 1st Session

LAWS 2011

CHAPTER 5

HOUSE BILL 432, as amended

Introduced by

REPRESENTATIVE ZACHARY J. COOK



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# Chapter 5

## AN ACT

RELATING TO BEHAVIORAL HEALTH; PROVIDING FOR THE ESTABLISHMENT OF AN INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE PILOT PROJECT TO CREATE A PARTNERSHIP OF A BEHAVIORAL HEALTH PROVIDER NETWORK AND ANOTHER ENTITY TO DELIVER BEHAVIORAL HEALTH SERVICES AND MANAGE CARE IN DESIGNATED AREAS OF THE STATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. TEMPORARY PROVISION--INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE--STATEWIDE ENTITY PILOT PROJECT.--

A. By July 1, 2013 and contingent upon federal approval of any necessary medicaid state plan amendment or waiver, the interagency behavioral health purchasing collaborative shall consider implementing a pilot project that provides for:

(1) a network of behavioral health providers, which shall form a partnership with another entity to submit a contract with a duration of at least two years for collaborative approval pursuant to Paragraph (2) of Subsection F of Section 9-7-6.4 NMSA 1978 to provide behavioral health services and to manage care as a regional behavioral health entity pursuant to Paragraph (5) of Subsection B of Section 9-7-6.4 NMSA 1978;

1 (2) a partnership between the network of  
2 behavioral health providers and another entity to establish a  
3 behavioral health entity that shall entail the network of  
4 providers having at least fifty-one percent control of the  
5 behavioral health entity; and

6 (3) a pilot project design that establishes  
7 the behavioral health entity to meet criteria for licensure as  
8 a risk-bearing entity by the insurance division of the public  
9 regulation commission.

10 B. As the interagency behavioral health purchasing  
11 collaborative deems necessary, it shall coordinate with the  
12 behavioral health entity established pursuant to Subsection A  
13 of this section to designate what region or regions of the  
14 state the entity will serve and conduct a readiness review to  
15 ensure that the entity will have the staff, resources,  
16 information technology, administrative procedures and other  
17 components in place to fully implement the pilot project and  
18 successfully deliver behavioral health services in the area to  
19 be served by July 1, 2013.

20 C. The interagency behavioral health purchasing  
21 collaborative shall amend its existing contract with the  
22 current statewide entity to provide, during the period of the  
23 pilot project's operation, for the exclusive implementation of  
24 the pilot project in designated areas of the state.

25 D. If necessary, the interagency behavioral health HB 432  
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1 purchasing collaborative shall seek federal approval of a  
2 state plan amendment or medicaid waiver to carry out the  
3 provisions of this section.

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OFFICE OF THE CLERK

SENATE OF THE STATE OF MISSISSIPPI

2000

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HOUSE OF REPRESENTATIVES

JOHN A. SANCHEZ, PRESIDENT  
SENATE

LENORE M. NARANJO, CHIEF CLERK  
SENATE

Approved by me this 17<sup>th</sup> day of March, 2011

SUSANA MARTINEZ, GOVERNOR  
STATE OF NEW MEXICO

Office of the STATE OF N.  
CLIFF COAST GUARD

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Beauregard

# US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers

1. Dante Morral,\* Sean Nicholson<sup>2</sup>, Wendy Levinson<sup>3</sup>, David N. Gans<sup>4</sup>, Terry Hammons<sup>5</sup> and Lawrence P. Casalino<sup>6</sup>

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## Abstract

Physician practices, especially the small practices with just one or two physicians that are common in the United States, incur substantial costs in time and labor interacting with multiple insurance plans about claims, coverage, and billing for patient care and prescription drugs. We surveyed physicians and administrators in the province of Ontario, Canada, about time spent interacting with payers and compared the results with a national companion survey in the United States. We estimated physician practices in Ontario spent \$22,205 per physician per year interacting with Canada's single-payer agency—just 27 percent of the \$82,975 per physician per year spent in the United States. US nursing staff, including medical assistants, spent 20.6 hours per physician per week interacting with health plans—nearly ten times that of their Ontario counterparts. If US physicians had administrative costs similar to those of Ontario physicians, the total savings would be approximately \$27.6 billion per year. The results support the opinion shared by many US health care leaders interviewed for this study that interactions between physician practices and health plans could be performed much more efficiently.

Cost of Health Care   Financing Health Care   Health Reform   Health Spending   Managed Care

Total health spending per capita in the United States, adjusted for differences in purchasing power, is 87 percent more than in Canada (\$7,290 compared to \$3,895 per year).<sup>1</sup> Many factors contribute to the high cost of health care in the United States, but there is broad consensus that administrative costs in the health care system are high and could be reduced.<sup>2-4</sup> Interactions between physician practices and health insurance plans are one prominent component of administrative costs.

We recently published the results of a survey of US physician practices that estimated the time spent by physicians, nurses, and office staff on interactions with health plans. The survey found that at least \$31 billion is spent on these activities annually in the United States.<sup>5</sup> These estimates are broadly consistent with the findings of other studies that used different methods.<sup>6-8</sup>

Physician practices in the United States must interact with many health plans in the US multipayer system. Moreover, interactions increase with plans' attempts to "manage care," such as requiring prior authorizations for many specialist, imaging, and hospital services. Each health plan offers many different insurance products to consumers, and each may have its own formulary (or list of approved drugs); prior authorization requirements; and rules for billing, submitting claims, and adjudication. In contrast, Canadian physicians generally interact with a single payer that offers a single product, and they are subject to fewer managed care requirements.

By estimating the cost to Canadian practices of interacting with the Canadian single payer, then comparing this to the cost to US practices of interacting with health plans, it is possible to provide an estimate of the "extra" costs to US physicians of the nation's multipayer, managed care system of health insurance. We conducted a survey of physician practice interactions with the single payer in Ontario, Canada, that paralleled our survey of practices in the United States. Ontario includes approximately one-third of the Canadian population; its single-payer model is generally representative of the Canadian system.

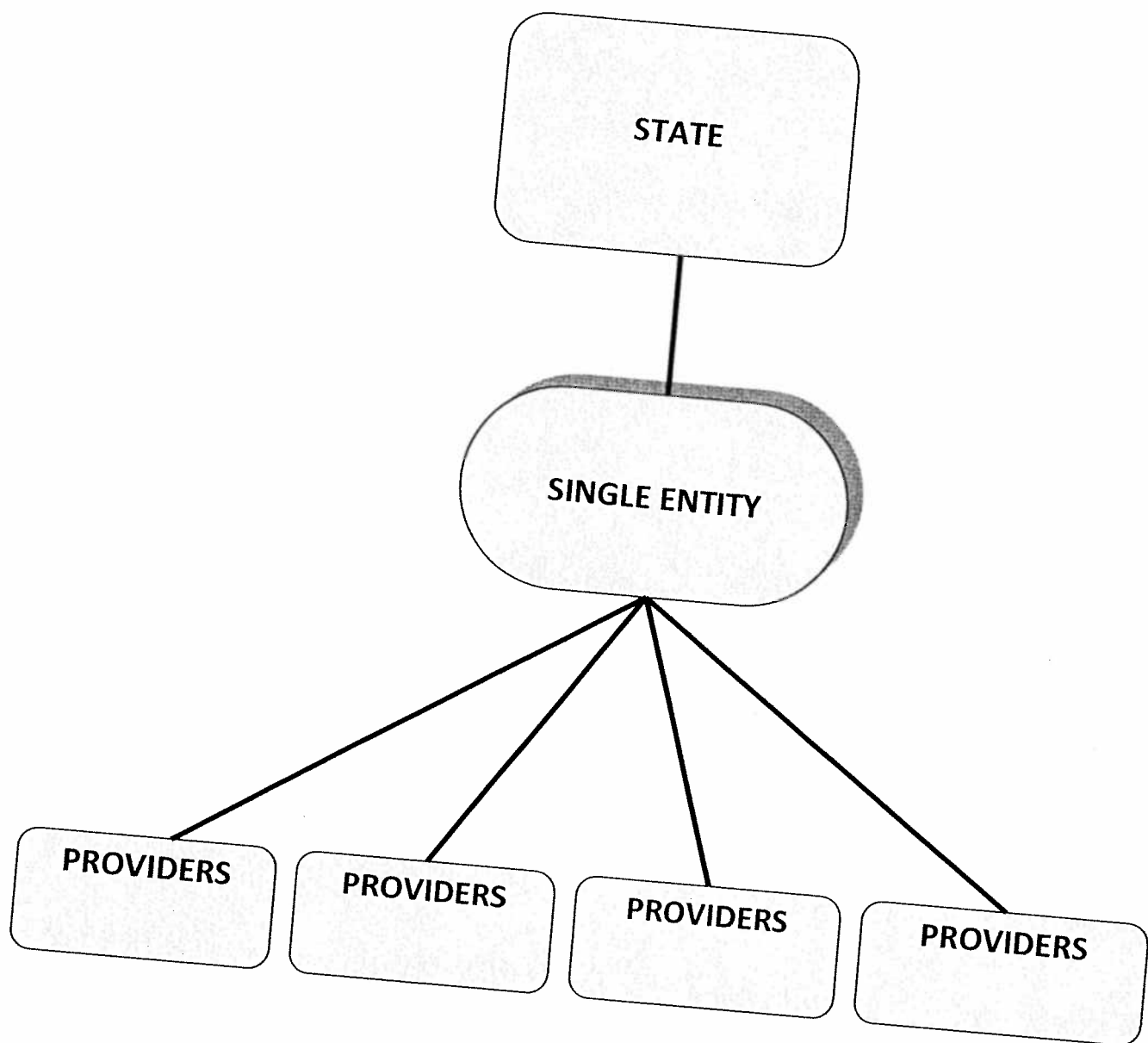
## Study Data And Methods

Details of the methods used for the US survey have been published elsewhere.<sup>5</sup> We present details of the methods used in the Ontario study, with reference to the US study when relevant.

## Sampling Strategy

Using the 2006 MD Select Canadian Masterfile (a Canadian database of physicians and large group practices), we sent surveys to a random sample of 150 family physicians, 180 specialist physicians, and the business managers of all 93 large group practices (three or more physicians) in Ontario that met our inclusion criteria. Our goal, in Ontario as in the United States, was to include office-based physicians in private practice, so we excluded physicians working in academic and hospital practices and physicians working in salaried delivery models such as Canadian Community Health Centers. We also excluded physicians whose revenues came mainly from patient self-payments rather than from payers, so we excluded physicians practicing outside of the single-payer system such as cosmetic surgeons.

# FLOW CHART OF FUNDING FOR BEHAVIORAL HEALTH



# FLOW CHART OF REGIONALIZATION

